



FIG. 1

14

MEMBER A

10

NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SS#: \_\_\_\_\_

BLOODTYPE: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

SPECIAL  
CONDITIONS: \_\_\_\_\_

NOTES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

FIG. 2

10

32  
MEDICAL

IMMUNIZATION RECORD

<u>TYPE</u>	<u>DATE</u>	<u>DATE</u>	<u>DATE</u>	<u>DATE</u>

MEDICAL		
<div>36</div> <div># <u>M</u> _____</div>	DATE:	<div>38</div> <div><input type="checkbox"/></div> <div>MEDICATION</div>
PURPOSE:		
PHYSICIAN:	CLINIC / HOSP:	
DIAGNOSIS:		
TREATMENT:		
FOLLOW-UP:		
<div># <u>M</u> _____</div>	DATE:	<div><input type="checkbox"/></div> <div>MEDICATION</div>
PURPOSE:		
PHYSICIAN:	CLINIC / HOSP:	
DIAGNOSIS:		
TREATMENT:		
FOLLOW-UP:		
<div># <u>M</u> _____</div>	DATE:	<div><input type="checkbox"/></div> <div>MEDICATION</div>
PURPOSE:		
PHYSICIAN:	CLINIC / HOSP:	
DIAGNOSIS:		
TREATMENT:		
FOLLOW-UP:		

MEDICAL

34

32

FIG. 4

FIG. 5

FIG. 5

DENTAL	
<div>46</div> <div># <u>D</u> _____</div> <div>PURPOSE:</div> <div>DENTIST / ORTHO:</div> <div>DIAGNOSIS:</div> <div>TREATMENT:</div> <div>FOLLOW-UP:</div>	<div>DATE:</div> <div><div>48</div><div><input type="checkbox"/></div><div>MEDICATION</div></div> <div>X-RAY:</div>
<div># <u>D</u> _____</div> <div>PURPOSE:</div> <div>DENTIST / ORTHO:</div> <div>DIAGNOSIS:</div> <div>TREATMENT:</div> <div>FOLLOW-UP:</div>	<div>DATE:</div> <div><div><input type="checkbox"/></div><div>MEDICATION</div></div> <div>X-RAY:</div>
<div># <u>D</u> _____</div> <div>PURPOSE:</div> <div>DENTIST / ORTHO:</div> <div>DIAGNOSIS:</div> <div>TREATMENT:</div> <div>FOLLOW-UP:</div>	<div>DATE:</div> <div><div><input type="checkbox"/></div><div>MEDICATION</div></div> <div>X-RAY:</div>
<div># <u>D</u> _____</div> <div>PURPOSE:</div> <div>DENTIST / ORTHO:</div> <div>DIAGNOSIS:</div> <div>TREATMENT:</div> <div>FOLLOW-UP:</div>	<div>DATE:</div> <div><div><input type="checkbox"/></div><div>MEDICATION</div></div> <div>X-RAY:</div>

DENTAL

42

FIG. 6

7 / 13

[illegible]

FIG. 7

VISION	
<div>56</div> <div># V <input type="text"/></div> <div>PURPOSE:</div> <div>PHYSICAN:</div> <div>DIAGNOSIS:</div> <div>TREATMENT:</div> <div>FOLLOW-UP:</div>	<div>DATE:</div> <div><div>58</div><div><input type="checkbox"/></div><div>MEDICATION</div></div>
<div># V <input type="text"/></div> <div>PURPOSE:</div> <div>PHYSICAN:</div> <div>DIAGNOSIS:</div> <div>TREATMENT:</div> <div>FOLLOW-UP:</div>	<div>DATE:</div> <div><div><input type="checkbox"/></div><div>MEDICATION</div></div>
<div># V <input type="text"/></div> <div>PURPOSE:</div> <div>PHYSICAN:</div> <div>DIAGNOSIS:</div> <div>TREATMENT:</div> <div>FOLLOW-UP:</div>	<div>DATE:</div> <div><div><input type="checkbox"/></div><div>MEDICATION</div></div>
<div># V <input type="text"/></div> <div>PURPOSE:</div> <div>PHYSICAN:</div> <div>DIAGNOSIS:</div> <div>TREATMENT:</div> <div>FOLLOW-UP:</div>	<div>DATE:</div> <div><div><input type="checkbox"/></div><div>MEDICATION</div></div>

52

VISION

FIG. 8



The diagram illustrates a medication form, designated by reference numeral 66. The form is organized into four identical, vertically stacked sections, each enclosed in a rectangular border. Each section contains the following fields: 'MEDICATION:', 'INSTRUCTIONS:', 'DATE:', 'QTY:', 'REFILL INFO:', 'PHARMACY:', 'PHONE #:', 'PRESCRIPTION #:', 'PRESCRIBED BY:', 'COMMENTS:', and a 'REF.#' field. The 'REF.#' field is represented by a rectangular box. Reference numerals 68, 70, 72, 74, and 76 are used to point to specific fields in the first section. A vertical label 'MEDICATION' is positioned to the right of the form, with a reference numeral 62 pointing to it. A reference numeral 22 points to the right side of the form, and a reference numeral 64 points to the right side of the first section.

66  
MEDICATION

68 MEDICATION: \_\_\_\_\_  
INSTRUCTIONS: \_\_\_\_\_  
DATE: \_\_\_\_\_ QTY: 70 REFILL INFO: 72  
PHARMACY: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
PRESCRIPTION #: \_\_\_\_\_ PRESCRIBED BY: \_\_\_\_\_  
COMMENTS: \_\_\_\_\_ REF.# 76

74 MEDICATION: \_\_\_\_\_  
INSTRUCTIONS: \_\_\_\_\_  
DATE: \_\_\_\_\_ QTY: \_\_\_\_\_ REFILL INFO: \_\_\_\_\_  
PHARMACY: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
PRESCRIPTION #: \_\_\_\_\_ PRESCRIBED BY: \_\_\_\_\_  
COMMENTS: \_\_\_\_\_ REF.#

MEDICATION: \_\_\_\_\_  
INSTRUCTIONS: \_\_\_\_\_  
DATE: \_\_\_\_\_ QTY: \_\_\_\_\_ REFILL INFO: \_\_\_\_\_  
PHARMACY: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
PRESCRIPTION #: \_\_\_\_\_ PRESCRIBED BY: \_\_\_\_\_  
COMMENTS: \_\_\_\_\_ REF.#

MEDICATION: \_\_\_\_\_  
INSTRUCTIONS: \_\_\_\_\_  
DATE: \_\_\_\_\_ QTY: \_\_\_\_\_ REFILL INFO: \_\_\_\_\_  
PHARMACY: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
PRESCRIPTION #: \_\_\_\_\_ PRESCRIBED BY: \_\_\_\_\_  
COMMENTS: \_\_\_\_\_ REF.#

62  
MEDICATION

22

64

FIG. 9

FIG. 10

<u>DATE</u>	<u>LOCATION</u>	<u>AMOUNT</u>	<u>DATE</u>	<u>LOCATION</u>	<u>AMOUNT</u>
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[illegible]

## TEST RESULTS

-78

FIG. 11

FIG. 12

PROVIDER DIRECTORY	
TYPES: VETERINARIANS, EMERGENCY VET HOSPITAL, BOARDER / KENNEL, GROOMER, ETC.	
NAME:	_____
ADDRESS:	_____
CITY:	_____ STATE: _____ ZIP: _____
PHONE #:	_____
94 TYPE:	_____
COMMENTS:	_____ _____
NAME:	_____
ADDRESS:	_____
CITY:	_____ STATE: _____ ZIP: _____
PHONE #:	_____
TYPE:	_____
COMMENTS:	_____ _____
NAME:	_____
ADDRESS:	_____
CITY:	_____ STATE: _____ ZIP: _____
PHONE #:	_____
TYPE:	_____
COMMENTS:	_____ _____

92  
DIRECTORY

FIG. 13